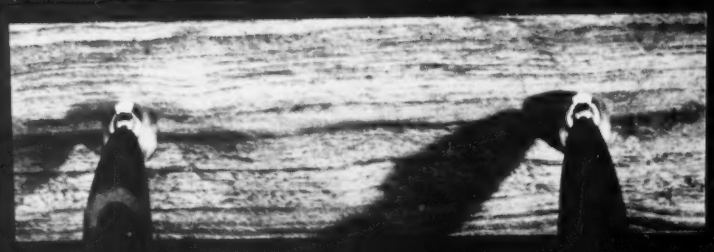
THE SOCIAL AND REHABILITATION Record

Assessing Needs New Rehabilitation Act
Supplemental Security Income Research & Development Policy Planning Regional News Early Screening

Social and Rehabilitation Service UNITED STATES DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE Volume 1 Number 1 December-January 1973-74



DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
SOCIAL AND REHABILITATION SERVICE
WASHINGTON, D.C. 20201

OFFICE OF THE ADMINISTRATOR

Dear Colleague:

In the spirit of the new directions being pursued in the social and rehabilitation field, a "new look" in our communications has emerged with the publication of this magazine. By consolidating several publications, we have created a new and, we hope, better tool for interchange of information among the social and rehabilitation community. We believe this medium, serving a broader spectrum of readers than its predecessors, can be invaluable to administrators and professional practitioners alike. Such a magazine should build on the merits but enlarge the scope of its predecessors. It should contribute broader insights into programs, highlight successful innovation in administration and service, and bring practical solutions to problems into sharp focus.

This the SOCIAL AND REHABILITATION RECORD will attempt to do. Along with the type of articles published by its forerunners, it will include key results of research and demonstrations, descriptions of new management techniques, and progress toward mutual objectives in the social and rehabilitation field. By reprinting some of its more pertinent articles for larger distribution, information will be made available inexpensively to many more persons who can put the knowledge to good use.

I also believe this new magazine can serve as an important linking element among Federal, State, and local jurisdictions and our friends in the private sector with whom we work. We hope its readers will not only receive benefit from its pages but will actively contribute to its content.

Yours very truly,

James S. Dwight, Jr.
Administrator

THE SOCIAL AND REHABILITATION
Record

Volume 1, Number 1 December-January 1973-74

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Two Chicano projects show first-year success

"Two organizations directed at the Chicano population in Colorado are completing a successful year of operation under SRS grants," reports Dr. James Dixon, research demonstration specialist. The two are the Mexican American Services Agency (MASA), Pueblo, and the Incorporated Mexican American Government Employees (IMAGE) in Denver.

MASA is composed of a group of Mexican American citizens whose goal is to "improve the living standards of the Mexican American in Pueblo." The organization is governed by a 30-member board. Its staff consists of five full-time employees; two work through an expansion grant.

Awarded in early 1973, the grant seeks the expansion of State vocational rehabilitation services for the Spanish-speaking population of Pueblo. One MASA staff member has assumed a full caseload of rehabilitation clients while the other is responsible for job placement of the clients under the MASA project.

Both staff members have greater flexibility in following up clients, particularly in Spanish-speaking communities, than comparable State employees, "which is the strength of the project," according to Mr. Eric Lucero of the State DVR.

The overriding purpose of MASA is not to upset the existing state of work, but to make it function better vis-a-vis the Mexican American.

A preliminary evaluation by an independent consultant firm shows reason for continuing the grant, "because of its demonstrated progress in meeting the needs of the Spanish-speaking community."

IMAGE is governed by a 10-member board. Conceived and developed in 1971 by Chicanos in Denver, it has grown into a national organization of federal, State, county employees, and of municipal government service agencies substantially funded by these sources.

IMAGE was originally founded to increase the number of Spanish-surnamed persons employed at all levels of government and to achieve equal opportunity for their advancement.

In 1972, the Denver IMAGE chapter was funded by SRS for $16,580 for a 1-year program operation (known as Image Skills Bank) with the aim of providing and improving employment opportunity.

To achieve its goal, its activities were divided into three phases: 1) identification of available jobs, 2) identification of qualified Spanish-surnamed job applicants, and 3) establishment of an ongoing job referral program.

In phase 1, the skills bank developed communications with and established an ongoing relationship with 26 federal and State agencies in the Denver area.

Phase II implements the primary goal by motivating and instilling in the potential Chicano government employee the desire and aspiration to gain employment. Over 53 organizations have been contacted by the IMAGE staff to explain the objectives of the skills bank and to solicit job applications or resumes.

Concentration of activities is presently being initiated in phase III. Over 300 persons have been referred to specific government agencies. Strategies are being developed to follow up on applicants to determine whether contacts have actually been made as a result of the referrals and whether applicants were hired. At present, the applicant is asked to report to the skills bank office whether or not placement was accomplished.

Louisiana reorganizes State agencies

The State of Louisiana is consolidating the work of 59 health and other resource agencies into one unit, a radical move toward better service for its people. The plan is akin to those in a number of other States which are embarking on similar programs to avoid overlapping and to maximize efficiency in providing health and social services.

Provisions for the new unit were made in the Reorganization Act of 1972, which went into effect in January 1973. It transferred the work of the Department of Public Welfare, Department of Health, and Department of Hospitals to a new Health and Social and Rehabilitation Services Administration (LHSRSA).

As an indication of the legislature's overwhelming support for reorganization, the bill passed the house of representatives, 91-0, and received a 34-3 vote in the senate.

In addition to its commissioner and deputy, the LHSRSA is run by a "superboard" of 15 Louisiana residents who are not State government employees. Twelve are in health-related professions; one is a union leader; and two are in the social service fields.

In addition to the health functions, the new agency has assumed responsibility for a broad range of human services, including advocacy, in such areas as protective services for families and children. The total range of social services, includes child care, services to the blind, and programs for the elderly. Income maintenance programs for families are also a major continuing State responsibility. The advisory board is working in various committees to redefine and recommend changes in State policy in each of the program areas.

Region VIII programs exceed WIN goals

"Region VIII ranks among the top in its achievement of assigned WIN II goals, exceeding national averages in virtually all areas of program operations," announces George Ivans, Regional Representative, Self Support Programs, Community Services. "In each of the 12 categories defined, Region VIII ranks first, second or third, except in the area of public service employment (PSE) placement."

As early as March, 9 of 12 annual goals set by WIN II had been reached. By then the region had achieved 80 percent of its annual goal for registrations, compared with the 68 percent national average.

Despite some difficulties in several States with "no shows" of registrants for the appraisal interview, the region had achieved 137 percent of its appraisal goal, compared with 73 percent nationally.

Similarly, in certifications, it certified 12,441 participants against the 10,600 assigned, representing 117 percent of its goal.

In total placements, the region was performing at a rate twice the national average. In direct (nonsubsidized) placements, it achieved 65 percent of its goal. Both placement categories represent performance superior to all but one other region. Although no goals were assigned for use of the tax credit, it had placed 1,200 persons with employers who claimed the tax credit. In an area of the country without major population centers and a large in-

dustrial base, this was considered a significant achievement.

In utilization of the OJT component, the region again performed at a rate twice the national average. Against a 33 percent rate nationally, Region VIII achieved 76 percent of its annual goal, performance surpassed by only one region.

The only deficient area was in the development of sufficient PSE jobs to meet the assigned annual goal. According to the regional WIN staff, this is due, to some extent, "to the nature of the region itself which is composed of six sparsely populated States and which include large geographic areas. State and local governments are small and must operate on budgets which would be considered miniscule in other regions. Many county and local units of government find it difficult to provide the necessary assurances of permanent employment for participants once the subsidized WIN jobs training period is completed."

Coupled with these factors, it was the feeling of regional WIN staff that PSE should be utilized only in those instances where participants could be placed into employment in no other way. Primary emphasis was accordingly placed on OJT or direct job placement. A further factor limiting PSE in the region was the reluctance on the part of regional and State staff "to see participants become ineligible for the income disregard as a result of accepting PSE jobs. Should this provision be changed or the maximum salaries permissible under PSE be revised upward, better performance might be expected."

The regional WIN staff attributes its successes to the strong and cordial interagency relationships existing between Labor and DHEW at the regional level. At the State level, a similar atmosphere of cooperation exists. In only one State has the welfare agency failed to establish a separate administrative unit, although full-time welfare staff was assigned to WIN.

California leads in employing the mentally retarded

Federal agencies in California led all States in the hiring of mentally handicapped employees with a total of 815 workers. It was followed by Illinois and Texas who tied for second place with 519 and by Missouri in third place with 401.

Since the U.S. Civil Service Commission started its special program in 1963 to encourage federal agencies to hire the mentally retarded, 7,442 persons have been employed nationwide. A total of 3,182 was employed for 3 years or longer. They worked in 117 different job classifications.

A major feature in the campaign is an agreement by federal agencies to use the services of State vocational rehabilitation departments in the direct placement, post-employment counseling, training, and supervision of mentally retarded employees. This commitment permits the substitution of a rehabilitation counselor's professional judgment for the standard testing procedures to determine employability of an applicant who is retarded.

California's counselors have played an important role in placing these people in the federal workforce.

Four Region IV States to integrate agencies

Planning assistance has been given to four States in Region IV to aid them develop well-functioning human recourse centers. These centers will be umbrella agencies for social services. Because of their embryonic development to date, assistance was perceived as needed in developing their administrative and management capacity.

Grant objectives call for hiring planning personnel who would develop systems and procedures to serve people affected by social, medical, and mental health problems. Thus, the centers could determine composite objectives for clients and better implement services to them.

Each planning project received $50,000 from the Regional Office as a first test use of decentralized regional funding. Because it comes from the Regional Office, the money can be dispensed when need by the States is ascertained. These planning grants were perceived as timely efforts. They also helped the States comply with the mandates of their legislatures to reorganize the social service delivery systems in their jurisdictions.

Involved in this effort will be planning, evaluation, and reporting, as well as service delivery. The four States to receive the grants are Georgia, Mississippi, and North and South Carolina.

Federal court kills Missouri welfare 20-hour work law

Before October 1973, Missourians otherwise eligible for public welfare were denied assistance if they were employed for more than 20 hours a week. This help was denied regardless of the person's financial need. These restrictions were put into effect under regulations enacted in 1953.

But the restrictions were lifted as the result of a federal court decision made recently in St. Louis.

The State welfare director told legislative officials that the decision would cost the State an extra $3.3 million a year. The legislative committee charged in these matters approved the additional funds so that payments to the newly eligibles would begin on October 1, 1973.

S.C. rehab program rooted in success

Participants in a South Carolina vocational rehabilitation horticulture program soon discover that the kindness which they bestow on the plants is directly reciprocated. The training project instills within each client a degree of enthusiasm, job discipline, and personal incentive. Furthermore, this rehabilitative and educational experience of caring for flowers and shrubs, of working in greenhouses, of training as horticulture specialists, and finally, of placement in satisfying job positions, crosses both age and ability barriers. Thus it has been introduced to three State institutions: a home for the mentally retarded, a correctional institute, and Columbia TEC.

Additional evidence attesting to the program's success may be found in the growth and development of independence, self-awareness, and inner security among participating VR clients—the blind, the mentally handicapped, the elderly offenders, and the hardcore unemployed and underemployed.

The Rehabilitation Act of 1973

KATHALEEN C. ARNESON

On September 26, 1973, President Nixon signed the Rehabilitation Act of 1973 (HR 8070). In so doing, he expressed the Administration's concurrence with the third version of these amendments enacted by Congress. Existing authority for the vocational rehabilitation program expired in June 1972.

In the course of 3 stormy years of legislative thrust and counter thrust, the President's vetoes of HR 8395 and S 7 reflected, and was a part of a larger struggle between the executive and legislative branches of the Federal Government for definitive control over the future direction of human services programs involving substantial amounts of federal funds.

Notwithstanding some of the rhetoric employed by contending spokesmen, there was no announced intention to destroy the Nation's vocational rehabilitation program for disabled people.

(There were and probably will continue to be fundamental differences of opinion about the extent to which this jointly funded State-Federal services program should be expanded to include services for disabled persons without manifest vocational potential, or whether its mission should continue to be confined to those disabled persons who have job potential. And, there are planners and management experts who periodically advance the hypothesis that the fundamental objectives of the VR program for people with disabilities can be accomplished through a simple system of counseling and referring disabled people, as their individual and particular needs would indicate, to other general Federal-State programs that provide education, vocational guidance, welfare payments, and health services for the population as a whole. The basic format of the program of services has always been retained, however.)

Unfortunately, the destructive intent idea became widespread. It affected the strategy and tactics of some participants throughout the legislative processes. Ultimately, however, compromise on specific issues was required, and the provisions of HR 8070 were drafted after a greater amount of consultation and accommodation between key executive and congressional leaders. This process also involved spokesmen for the general public and the rehabilitation leadership outside government.

It is important for rehabilitation workers to understand why compromise and agreement were delayed. Understandably, the Administration wished first to accomplish its basic welfare reform objectives. This absorbed the time and energy of the Department's leadership during the first 2 years, when rehabilitation legislation was also under consideration.

In addition, as preparations were made for hearings on the first rehabilitation bills in the 92nd Congress, there was growing congressional anxiety about the proper use of appropriations under the existing Act. This stemmed in part from disagreement on the part of some congressional leaders with the basic policy of SRS to redirect some funds, appropriated under the authority of the Vocational Rehabilitation Act for programs and activities that would improve services for disabled people, away from traditional uses for these demonstration and research funds.

There was concern, also, about the implication of Administration decisions to phase out certain authorized activities and programs under the Act. Despite the attitude of the Congress and rehabilitation leaders, the Administration requested what seemed to be inadequate amounts or no funds from Congress to carry out certain functions, *e.g.*, reduction in the amount of funds to train professional staff to work in rehabilitation programs. Similarly, no funds had been requested for several years for construction of rehabilitation facilities.

This policy of withdrawal of federal financial responsibility for "capacity development," always identified as a significant element in the availability and adequacy of services to disabled people, drew sharp protests from rehabilitation leaders. They were joined by professional organizations concerned with the Nation's supply of such key practitioners. It was characterized as pennywise but pound foolish.

Other real and very specific program and management issues at the heart of the struggle were often obscured or blurred in the public expression of differences of opinion as the overall debate and legislative action progressed. Out of the testimony and congressional analysis of all facets of the vocational rehabilitation program, many significant issues were developed which required the vigorous debate they generated. Differences could be resolved only through compromise. They revolved around the following:

- The size of the federal dollar commitment and the basis for apportionment (the distribution formula);
- The extent to which the law would mandate services to greater numbers of the most severely disabled and the specific manner in which this emphasis would be spelled out;
- The nature and size of the federal financial investment in a complementary service or research program for severely

disabled people without vocational potential but whose functioning could be improved;

■The extent to which federal priorities established by the Department of Health, Education, and Welfare would control or influence the use of federal funds, especially those for projects;

■The degree and nature of consumer or client participation in the design and delivery of services, including client advocacy;

■The increase in the degree and changes in the nature of congressional monitoring of programs, including more explicit arrangements to oversee and evaluate State programs;

■The relative amount of emphasis in the Act (and in the work of the staff of the Rehabilitation Services Administration) upon other important issues affecting all disabled people but peripheral to the administration of the federal funds for the basic support program for rehabilitation services. Examples are nondiscrimination in federal grants and contracts, employment of handicapped persons in the federal service, and elimination of architectural and transportation barriers affecting the mobility and life style of all disabled people;

■The degree of "independence" of the RSA Commissioner in administering provisions of the Act intended for the physically and mentally disabled and not for other disadvantaged people;

■The establishment of an identifiable officer in the Department whom the Congress could hold accountable for administration of the Act.

The hearings records and committee reports on the vetoed bills describe the rationale for the inclusion of certain innovative features in the bills reported out by the Senate Labor and Public Welfare Committee and its Subcommittee on the Handicapped and by the House Committee on Education and Labor and the Select Subcommittee on Education. Counter arguments are found in the statements of Administration spokesmen before the committees and in the veto messages of the President.

Because of federal budget constraints, the Administration originally sought a reauthorization of the current program at existing levels of funding with minimum changes. The few changes recommended reemphasized vocational objectives and provided for more efficient and flexible administration at State and local levels. Administration proposals also directed primary attention to serving low income people, especially those on welfare rolls, and provided more client and citizen involvement.

These Administration proposals were criticized as inadequate in the light of unmet needs for more services to greater numbers of potentially eligible clients. The suggested emphasis on low income people was interpreted by some as an effort to make the program an appendage of the costly and controversial welfare program and a vehicle for helping to re-

make the welfare program for needy adults from a minimum income maintenance program into a cost-effective social service system which returned heads of families in poverty to the work force.

Certain key Members of Congress countered the announced Administration proposals with their own amendments, even before the long-delayed Administration bill was introduced. Their bills called for the program to continue channeling services only to disabled people and to expand it greatly, with authority to serve increased numbers of clients.

Further, the amendments called for services to the more severely handicapped who probably could not be expected to enter the labor market but whose functional independence and life situation could be improved with vocational rehabilitation service. Other initiatives included a client advocate system and new authorities and funding mechanisms to develop special programs for particular groups (low-achieving deaf, older blind people, people needing kidney dialysis, and the spinal cord injured).

Following the first round of hearings Congress decided that downgrading of the role and responsibility of the RSA Commissioner should be prevented by specific language in the statute. Also, greater emphasis should be put upon evaluation of Federal and State rehabilitation operations and on research and demonstration.

The bills reflected Congress' view that the Department should enhance service to disabled people by creating an Office of the Handicapped to encourage long range planning and evaluation and better coordinate Departmental programs serving disabled people. They included special emphasis on better information and technical assistance to disabled people and nongovernmental groups.

The list of new proposals grew to include prohibition of discrimination against disabled people in the administration of all federal grant and contract programs, new approaches to the placement of the handicapped in federal employment, enforcement of existing federal architectural barrier laws, and studies of housing and transportation problems which effectively bar successful integration of disabled men and women into society.

As the Administration and Congress traded views, both sides altered their positions and worked toward a common center. The result is Presidential approval of the third bill.

It is a forward-looking but fiscally more restrained approach to the rehabilitation of greater numbers of disabled people for the next 2 years for which federal moneys are authorized.

The law, P.L. 93-112, includes scaled-down versions of many of the new approaches to services improvement and some priority for the severely disabled with vocational possibility. It includes, as well, a study designed to prepare persons with the most severe handicaps for entry into programs under the Act and to assist others who cannot be expected to be rehabilitated for employment but for whom rehabilitation could improve ability to live independently and function normally within family and community.

Unacceptable dictation of organizational structure in the Secretary's office to handle oversight of all programs for the disabled gave way in the compromise to more modest proposals to coordinate and improve the performance of departmental activities for the rehabilitation, education, and health of disabled children and adults. Provision was made to recognize in law the status of the Rehabilitation Services Administration and the importance of the position of the Commissioner of the agency.

In the months ahead, the budget requests and amounts appropriated will either promote or frustrate the compromises reached in the protracted debate on the terms of the authorizing federal legislation. Clear public demand and strong Administration backing for advance federal funding for the basic Federal-State program, and for necessary research, training of rehabilitation professionals and the authorized studies, projects and interagency activities will forecast intention to strengthen this successful program.

Wholehearted support from the public, leaders in the Executive Branch, and from both parties in the Congress has always met comparable response for matching funds from legislative and administrative bodies in the States and local communities. Intentions will also be signaled by prompt attention to and the provision of adequate financial and other resources to get underway the important studies on services to severely disabled persons, the workshop study and on formula changes for distribution of federal funds.

Congress has made clear its intention to maintain a close oversight of this legislation and program and activities conducted thereunder. The Oversight Hearings of the House Select Subcommittee on Education, begun in August of 1973, are recessed. They will resume at the call of the Chairman. Committees of the Senate have tentative plans to undertake special inquiries into the administration of this and other laws directly related to improving the situation of disabled people in the society. This clear evidence of continuing appraisal of the programs and President Nixon's statement as he signed the Rehabilitation Act of 1973 are auspicious: "The process of hammering out a compromise on this matter was long and difficult. It is heartening, however, that neither the Congress nor the Administration allowed the smoke of legislative skirmishes to obscure the goal we have shared from the first—that of continuing and improving a program which has long been one of the most humanitarian and effective of all federal grant activities. The compromise which has now emerged augurs well for progress on many other fronts where the American people are anxious for legislative action."

Mrs. Kathaleen C. Arneson is Director, Policy Research and Legislation, Rehabilitation Services Administration, SRS.

HIGHLIGHTS OF THE ACT

Outline:

Title I—Vocational rehabilitation services.

Part A—General provisions.

Part B—Basic vocational rehabilitation services.

Part C—Innovation and expansion grants.

Part D—Comprehensive service needs, special study.

Title II—Research and training.

Title III—Special federal responsibilities.

Title IV—Administration, Program, project evaluation.

Title V—Miscellaneous.

Authorization For Appropriations:

$1,546,400,000 over 2 years, plus additional sums as necessary.

Services for Severely Handicapped:

The State plan must:

- Include method to be used to expand and improve services to the most severe handicaps.
- Show that in event services cannot be provided to all, consideration must be given to serving the severely handicapped.

Client Interest:

Individualized written programs are required for each client, developed jointly by counselor and client or parent or guardian. Program sets forth terms and conditions, rights and remedies under which goods and services will be provided.

Authorizes from 7 to 20 pilot client assistance projects to provide special counselors to inform and advise all clients of all benefits under the Act.

Research, Demonstrations, Training:

Title II authorizes establishment and support of centers for research and training and engineering research; research in spinal cord injury and end stage renal disease; and a program for international research, as well as a general rehab research program.

New Programs, Expansion of Present Programs:

Combines the old innovation and expansion grants programs into a new formula grant project program based on population.

- Up to 50 percent of the funds available to any State may be expended only in connection with projects that require prior approval of the Secretary.
- The federal share may not exceed 90 percent; nonfederal share may be in cash or kind.

Programs for the construction of rehab facilities, and vocational training services authorized by the old Act are retained. A new program for mortgage insurance for mortgages on rehabilitation facilities is authorized.

Special projects and demonstrations are authorized for paying part of the costs of projects which expand or improve rehabilitation services.

Programs for Special Disabilities:

Maximum cooperation with the VA is required.

Program and project evaluation originally authorized under the VR Act are strengthened.

The Secretary must conduct an original study of sheltered workshops in the rehabilitation and employment of handicapped persons, including a study of wage.

Special program and management responsibilities are assigned to the Secretary.

- A study is required of the method of alloting basic support funds to the States which shall include the needs of individuals, the financial capability of the State to furnish services, State tax rates, and others.
- An Interagency Committee on Handicapped Employees is established to ensure hiring of handicapped.
- An Architectural and Transportation Barriers Compliance Board is established to ensure compliance with legal and regulatory requirements to eliminate barriers in public buildings built with federal funds.
- In making grants or contracts in excess of $2,500, the Federal Government is required to see that the contractor takes affirmative action to hire and advance handicapped people.
- No otherwise qualified handicapped person shall, solely by reason of his handicap, be excluded from or denied benefits of any program or activity receiving federal funds.

Additional Information:

A more complete version of these highlights may be obtained from: Director, Policy Research and Legislation, Rehabilitation Services Administration, 330 C Street, S.W., Washington, D.C. 20201.

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Statewide Success For Early Screening Diagnosis & Treatment

WILLIAM E. KEITH

In early 1969 an amendment to Title XIX of the Social Security Act established a new child health program to screen, diagnose, and treat all Medicaid eligible children under age 21. The Act, which organized EPSDT around the existing Medicaid system, requires the States to make health screening and treatment available to all Medicaid eligible children and youths under the age of 21.

EPSDT is now underway in varying degrees of development across the country. Here is how it's working in Mississippi.

Soon after becoming director of the Mississippi Medicaid Commission in January 1970, Dr. Alton B. Cobb called upon the State Board of Health to organize the State's EPSDT program.

Actual screening began just a few weeks later, in March. During the next 9 months, 8,833 screenings were carried out. Screenings of approximately 15,000 more youths took place in 1971, followed by some 14,000 in 1972. Health officials expect to screen about 20,000 additional cases this calendar year. Dr. Frank M. Wiygul, director of the health department's General Health Services Division, says, "Our goal is 50,000 screenings in 1974."

Mississippi's jet-propelled start and its high-volume followthrough are in sharp contrast to the situation in some States where complete development of Medicaid screening has been delayed for a wide variety of reasons. To the Mississippians involved, however, the story behind this fast start is easy to explain. Each of the State's 82 counties has its own county health department and its own welfare department, thus providing a small army ready to "take to the field" on short notice.

"My first thought," recalls Dr. Cobb, "was to do the screening through the organized public health program, using its facilities, personnel, experience, and administrative structure. That way, we could design a statewide program in cooperation with all concerned and see it implemented in every county."

Since its creation in 1877, Mississippi's State Board of Health has emphasized the importance of grassroots service at the county level, so the concept is nothing new to the State. In fact, any other approach to health programs is difficult for many Mississippians to understand. Even before Medicaid came into being, the General Health Services Division of the State Board of Health was planning statewide multiphasic health testing, in large part due to the work of Ted Griffith, a U.S. Public Health Service assignee to Mississippi in 1968.

Griffith, who has been with the Regional Medical Program in Atlanta, was instrumental in setting up the procedures for multiphasic health testing. The General Health Services Division was already experienced in—and geared up for—widespread testing when Dr. Cobb approached it regarding Medicaid screening in 1970.

"At about this same time," says Dr. Wiygul, "Dr. William J. Gillespie, who was then with the heart program of the State Board of Health, was doing field trials with a PhonoCardioScan. He asked us if there weren't some other tests that could be conducted in his clinics. We began building a simplified form of screening and gradually developed the program we're using now."

Playing key roles in getting Medicaid screening in motion were Terry Beck, supervisor of the General Health Services Division, and Miss Gerry Parish, the Division's social worker. They soon became known as the Terry-Gerry team, as they made the necessary administrative contacts at the State level. At the same time they kept in daily touch with the county health departments.

Dr. Hugh B. Cottrell, State health officer and executive director of the State Board of Health, supported the concept from the start. Officials of the State Department of Public Welfare extended immediate cooperation. In a State like Mississippi, agency people know each other and work together as a matter of course.

The first need was to identify the target population. The Child Welfare Division of the State Department of Public Wel-

fare came through in this phase of development by providing Dr. Wiygul's team with up-to-date lists of Medicaid-eligible people in each of Mississippi's 82 counties.

"We went first to the counties which were ready and willing to begin," says Dr. Wiygul. "County health department clerical personnel mailed notices inviting parents of eligible children to bring them in for screening. The notices were signed by both health department and welfare department officials of each county."

Many families responded immediately, says Dr. Wiygul, "because they are interested in health and they see the benefits of examinations. Then, too, each of the 119 screening clinic locations is within comparatively easy reach of the people it serves."

Families which did not respond to the first invitation had additional opportunities to keep appointments at subsequent clinics. Public health nurses, welfare visitors, and community outreach workers called personally on families not responding.

"Each person who comes in," says Dr. Wiygul, "is a patient of a public health nurse in a local district, and that nurse is personally interested in each individual."

The screening is done by teams consisting of a technician, a clerk, and two nurses—or sometimes one nurse and a health aide. They all work under a physician's supervision.

The nurses, clerks, and aides are "home folks," but the six technicians travel, as do Dr. Wiygul, Terry Beck, and Gerry Parish. Now that the procedures are well established, these three function primarily as "troubleshooters," ready to move immediately to any location where the machinery has temporarily bogged down.

Important to the success of the screening program is the procedure set up by Dr. Wiygul and others. It is comprehensive enough to meet all the requirements of the program and, at the same time, simple enough to be utilized by non-doctor teams working under medical supervision.

The screening includes a medical history taken by a clerk or a volunteer, a height-and-weight check made by an aide, a PhonoCardioScan screening performed by a technician, visual tests made by a nurse or an aide, the audiometric examination carried out by a nurse, the throat inspection and tuberculin skin test done by a nurse, hematocrits by the technician, and so on.

"The exit interviews are extremely important," says Dr. Wiygul. "The nurse talks with the child and with the family. Each person then knows exactly what should be done upon returning home."

Here again, the fact that each of Mississippi's 82 counties has its own health department and welfare unit means that followup services are within easy reach. And these followup services are critical to the success of the EPSDT effort. For without needed treatment, much of the screening effort is wasted.

Over and over again, in talking with Dr. Wiygul and with Terry Beck, the importance of simplicity is stressed.

"In the beginning, for example," says Dr. Wiygul, "it was much easier for us to do our first screenings in smaller counties, where the structure is simple."

And Beck spells out the basic procedure in simple language:

"First, identify your eligibles and provide for the release of data on the 'screenees'.

"Second, work with your provider staff—health departments and others—in establishing clinics on a regular basis.

"Third, provide for staff orientation by a physician (preferably a pediatrician) and by a nurse who is knowledgeable in pediatrics. Orient the staff to what is expected of them. They need to understand the philosophy behind the program.

"Fourth, your administrative people must give their attention to identifying the target group. The clerical people play a key role because they do the case intake."

All examinations are recorded; abnormal findings are reviewed. Those needing medical attention are sent to their physicians or to health department clinics.

Case management—to assure that children with some abnormality are actually treated—is done at the county health department. Officials working with the Mississippi EPSDT program are aware of the State's need for a centralized tracking system. Such a system is, in fact, being developed.

Mississippi, however, has an inadequate number of physicians and dentists in its rural counties. Diagnosis and treatment after the screening procedure is thus not always assured in these outlying areas.

"Our screening teams deal with reality," says Dr. Wiygul. "Too many people assume everybody has a family doctor. But that's not true. As a matter of fact, *half the children we screen have never been to a doctor except, perhaps, for some specific injury or ailment.*"

The State Board of Health cost for the service is $13 per child, which includes $1 for dental services. In counties where there are no physicians available, the State Board of Health contracts with other pediatricians or physicians to go in and do followup evaluations and carry out treatment. The welfare department in each area is advised of all positive findings.

Not only are all the Medicaid requirements met, but a number of special supplements—nutritional services, social services, immunizations, and other preventive measures—are available to the Medicaid Commission at no additional cost.

Dr. Cobb points out that the system used in Mississippi may not automatically be the best system for other States to use, but he notes that the Mississippi approach "enables you to use your available resources better."

"I could write a book about the advantages of using an existing system for Medicaid screening," he adds, "and nobody in Mississippi would doubt that."

Mr. Keith is a health writer and consultant in Jackson with wide experience in Mississippi health affairs.

ROBERT KRUGHOFF

Shortly after former HEW Secretary Richardson took direction of the Department in the summer of 1970, he identified as a top priority the assessment and improvement of the Department's research and demonstration (R&D) activities.

He charged the Assistant Secretary for Planning and Evaluation (ASPE) with a number of responsibilities to carry out this improvement effort. The responsibilities covered all aspects of the R&D process, including identification and selection of subjects for R&D, monitoring of individual studies on these subjects, and dissemination and utilization of R&D results.

From the studies that followed, one new mechanism—a process for the development of "policy implication papers"—emerged. It is being established at HEW to improve the dissemination and utilization of R&D findings. The mechanism focuses on only one aspect of dissemination: *communication from R&D offices to federal program decisionmakers* (as distinguished from dissemination of R&D findings to practitioners in the field).

The first step in establishing the new mechanism occurred in December 1971. At that time, the Secretary issued to the Department a "Research and Evaluation Guide." One requirement of that guidance statement is that each R&D office in the Department prepare "policy implication papers" whenever such a paper is justified by the accumulated findings of completed projects.

These policy implication papers identify policy or program changes which the R&D officials believe should be made by one or more federal program decisionmakers (*e.g.*, the Commissioner, Rehabilitation Services Administration). Changes might involve new legislation, altered budget levels, new program guidelines, new HEW policy statements, or similar action. The papers discuss the R&D evidence supporting the recommended changes.

The R&D office is expected to transmit the papers to the appropriate federal program decisionmakers, with a copy to ASPE. Upon receiving a policy implication paper, a federal program decisionmaker is expected promptly to respond—accepting the recommended change contained in the paper and describing his plans for its implementation, rejecting the recommendation and explaining why, or requesting further information.

Any response, other than outright acceptance *in toto* of a paper's recommendations, will usually require further involvement by the R&D office. For instance, if a recommendation is rejected, the R&D office will ordinarily want to defend its initial proposal against the reasons for rejection cited by the program decisionmaker. Thus, a dialogue will begin which should eventually result in agreement or in appeal to higher levels in HEW for resolution.

The Office of ASPE, as staff for the Secretary, having received copies of each of the policy implication papers produced by the R&D offices in the Department, can periodically select a sample of the papers for review. In these reviews it can ascertain whether program decisionmakers are seriously considering, and thoughtfully responding to, the recommendations of the R&D offices. It can observe whether R&D offices are producing papers which warrant such serious response and determine whether these offices are able to defend their recommendations in a dialogue with program decisionmakers.

This "policy implication paper" process has several values:

- It assures that R&D offices will actively search for usable findings and will synthesize the findings of various studies into actionable evidence. The offices thus cannot simply shelve findings and hope they are discovered.
- It assures that federal program decisionmakers pay attention to R&D findings and think about recommended innovations.
- It creates incentives for the R&D office to plan and fund projects which can be expected eventually to lead to usable findings and policy implication papers. Thus, the R&D office and the research community have a strong incentive to keep in touch with the needs of the practitioner and policymaker.

A particular virtue of the process is that it fosters exchange of information at a bureaucratically horizontal level between R&D offices and the program people who will have direct responsibility for using R&D results. An alternative process (which was considered) would have required communications to be directed from the R&D office to the Secretary's Office, or at least to heads of such major HEW agencies as SRS, so that these higher officials could then reach decisions on the recommendations in the papers. But the process as it now stands saves high level decisionmakers from having to be involved in every communication and having to become familiar with every issue. It can be hoped that good decisions will ordinarily result simply from the dialogue—even without intervention from higher levels.

The process of producing policy implication papers is, of course, recognized as only one of many ways in which R&D offices can disseminate their findings to federal program decisionmakers. Other less formal communication channels remain at least as important. The Secretary's guidance contemplates only a limited number of policy implication papers in areas where this formal mechanism is especially important to assure serious dialogue. It is also recognized that not all research activities are of such an "applied" character that they can be expected to yield recommendations for program or policy within a foreseeable time frame.

In view of this general background on the policy implication paper process, it is useful to look at SRS as a fairly typical illustration of the current state of the policy implication paper process. SRS has several policy implication papers at various stages of preparation, followup, or implementation by program decisionmakers.

One example is the paper, "Foster Care and Adoption," prepared by staff of the Division of Studies on Social Services and Life Support in SRS' Office of Research and Demonstrations. It is addressed primarily to the Commissioner of the Community Services Administration. Among the several "implications" contained in this paper are the following:

- Adoption of children should be encouraged by amending regulations (Sec. 220.19, §(d)) so as to stipulate that if adoptive homes are not readily available, an attempt should be made to place children in subsidized adoptive homes.
- Legislation should be amended (H.R. 1, Sec. 427 (a) (2) (b)) to permit extra payments for the adoption of the harder-to-place children of minority families and older children as is now the case for physically and mentally handicapped children.

Another example is an SRS paper on follow-along prepared by the staff of the Division of Rehabilitation and Employability Research. This paper recommends that regulations under a new Vocational Rehabilitation Act provide for services to be rendered clients beyond the usual time of case closure, and that the regulations

define these services in terms of the particular procedures available, the providers, the duration, and the primary target groups.

Other SRS papers either in preparation or scheduled for preparation will address such subjects as: housing and living arrangements for the aging; vocational rehabilitation of the addicted client; sensory aids for the blind and visually impaired; approaches to the definition of the "severely disabled."

Policy implication papers do not themselves represent SRS policy. They are simply recommendations of the SRS R&D office. The R&D office itself acknowledges that it is not aware of all of the resource tradeoffs, Congressional commitments, and other factors which determine whether a recommendation should in fact be accepted. But the papers are expected to be as realistic as possible with regard to such factors so that the recommendations deserve consideration.

This process of developing and promoting policy implication papers is still new in SRS, and throughout all of HEW. The quality of the papers and of the ensuing dialogue should continue to improve when the following developments occur:

- The staffs of R&D offices get more practice at marshalling evidence in a way which is persuasive to program decisionmakers;
- The R&D staffs become more familiar with the problems which concern these decisionmakers and begin to design projects to address these problems;
- The researchers in the field begin to feel greater demand for policy implications;
- The program decisionmakers become more practiced in dealing with research evidence;
- The R&D staffs and program decisionmakers build stronger personal relationships with each other as a result of dialogue surrounding each paper.

Already, the process has highlighted many important ideas for program change. Furthermore, it has been greeted with enthusiasm by research staffs, who regard it as a way to assure that their ideas get a fair hearing, and by program decisionmakers, who see in it a way to assure that researchers address practical program needs.

Mr. Krughoff was Director of Research and Evaluation Planning at HEW until his retirement from Government in June.

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SSI: The What and How

ARTHUR E. HESS

While the original Social Security Act was grand in design, it was somewhat limited in its initial coverage. The Act established two national social insurance programs—a federal system of benefits for retired workers and a combined Federal-State program of unemployed insurance. In addition, it provided for federal grants-in-aid to States for needy persons in three categories—the aged, blind adults, and dependent children. It also authorized grants to States for maternal and child health, services for crippled children, and child welfare.

Although both systems were incorporated in the same legislation, they have proceeded along parallel but separate lines in respect to financing bases and administrative structures. Today we are at a watershed in the evolution of our social programs as the Social Security Administration (SSA) integrates the basic social insurance with the program of supplemental security income (SSI) for the aged, blind, and disabled, for many of whom social insurance alone is not a total answer to special needs.

The significance of the Social Security Amendments of 1972—or at least that portion dealing with SSI—will continue to increase until, in years to come, it will achieve historic proportions.

On January 1, 1974, that segment of the current public assistance programs referred to as the adult categories—aid to the aged, blind, and disabled—will cease to exist in the 50 States and the District of Columbia. Replacing them will be a new program, constituting the first significant departure in concept and implementation of programs of financial assistance in 3 1/2 decades.

The SSI program provides for a sharing of responsibilities between the Federal and State Governments, with each level responsible for those tasks it is best equipped to perform. Only the Federal Government has the resources to assure establishment of a basic uniform income floor throughout the Nation, and only the Federal Government can establish uniform standards of eligibility and provide for

uniform national administration. The financing base of existing public welfare programs, on the other hand, rests to a large extent on the capacity and willingness of States to provide a realistic minimum income floor.

But the States still will play an essential role in a new kind of partnership with the Federal Government. Provision of social services, determination of disability or blindness, and decisions concerning referrals for vocational rehabilitation will continue to be State responsibilities.

The program will bring to SSA people with significantly different problems from those we now serve. To a much greater extent, many recipients probably will require a variety of social services.

SSA is even now engaged in pilot projects to determine how best to provide an information and referral service. It is possible that our approach will change as the results are evaluated. At the very least, we are committed to seeing that recipients are made aware of community resources and are referred for appropriate services. The need for meaningful collaboration between the Social Security Administration, State offices, and other public and private social welfare agencies is well recognized.

The question of State supplementation of the basic federal payment has numerous ramifications. In several States, the basic floor will be less than the current payment. An amendment which became law last July 9 protects recipients on State public assistance rolls on December 31, 1973, against a reduction of income. P.L. 93-66 provides that States must maintain the income of these aged, blind, or disabled recipients at their December 1973 level in order to be eligible for federal matching funds for Medicaid. Moreover, States will be encouraged through financial inducements to supplement the basic federal payment of new recipients where this is necessary to maintain present State payment levels.

A State may administer its own supplement. In this event, the State will have the right to set its own eligibility standards for new recipients, but it will bear the full cost of the supplemental benefits and their administration.

Where agreement is reached for a federally-administered supplement, the Federal Government will assume all of a State's cost of supplemental payments which exceeds its nonfederal share of assistance expenditures for the aged, blind, and disabled for calendar year 1972. This "hold-harmless" provision applies only to State supplementation needed to maintain the State's January 1972 assistance levels.

The fact that enactment of the SSI program was dictated by a sense of fairness and a desire to bring equity to a situation marked by inequity has not diminished the knotty problems inherent in planning for its implementation. Secretary Weinberger has characterized the program as "perhaps the largest civilian operation the Federal Government has undertaken since Medicare;" but, while the task is formidable, it is not insurmountable.

Detailing each problem encountered and its applicable solution would be a more appropriate exercise for a textbook than for an article. Some understanding of the undertaking's magnitude, however, can be gleaned from even a casual review of our efforts to date. In doing so, one should bear in mind that these planning activities are all geared to the distribution of approximately 6 million checks next January, not a small number even by today's standards.

Case conversion—the transfer of State records to SSA for determining eligibility of current State adult assistance recipients—will continue through the end of the year. This procedure alone will eventually involve the records of approximately 4 million recipients whose status must be checked against the new program's eligibility requirements. Except for the provision requiring that payment levels be maintained, there is no provision for the automatic blanketing-in of current recipients; only resource limitations, the definitions of disability and blindness, and income disregards for the blind can be grandfathered.

Information from the records of 79 jurisdictions—50 States, the District of Columbia, and several large counties and metropolitan areas—is being made available to the Federal Government. The process includes obtaining the data elements needed to determine eligibility and converting the data to machine-usable format. Benefits can then be computed, an appropriate "award" or "denial" notice sent to recipients, and payments made, beginning in January.

Realizing the complexity of the task, we conducted case conversion surveys in all States from January through April 1973. This resulted in a tentative plan of action which was incorporated into a formal contract between the State and

SSA. The contract, in part, specified the data processing procedures to be used, whether magnetic tapes, punch cards, or paper coding forms. All States currently are involved in some degree of conversion activity, and each is monitored to determine if time schedules are being met.

The flexibility permitted States in recognition of their uniqueness is illustrated

by the options provided in regard to the Medicaid program for new recipients. These options will permit States to exercise a measure of control over Medicaid costs and caseload increases.

P.L. 93-66 protects the Medicaid eligibility of certain persons for whom coverage would otherwise end in January 1974. These include essential persons (usually the ineligible spouse of an aged recipient), people in medical institutions, and blind or disabled, medically indigent persons eligible for Medicaid coverage in December 1973—as long as they continue to meet Medicaid eligibility criteria.

Coverage will not have to be extended to newly-eligible cash assistance recipients. A State may, if it chooses, extend Medicaid to all SSI recipients or may limit coverage by applying any of the more restrictive eligibility factors from its January 1972 medical assistance standard. Where coverage is limited in this fashion, the State must deduct medical expenses from income in determining eligibility for those with incomes above the 1972 standard. It may also extend coverage to those receiving a State supplemental payment, subject to specified income limitations, and may do so for any reasonable classification of recipients.

For newly-eligible persons, essential persons not eligible in their own right for supplemental security income payments will not be covered for Medicaid. Neither will disabled persons who do not qualify under SSI's definition of disability, nor individuals whose incomes are above the SSI or Medicaid standards.

Should a State provide Medicaid coverage for everyone eligible for SSI payments, the Federal Government may agree to determine Medicaid eligibility for these recipients as well as for people receiving a federally-administered State supplemental payment.

In addition to the conversion of those already on the public assistance rolls, new applications are being accepted in the 1,100 social security offices throughout the country. Current projections indicate that perhaps as many as 3 million applications may be filed by January 1, 1974.

These new responsibilities have, of course, necessitated an expansion in facilities and personnel. During the past year, SSA has hired approximately 11,500 new employees, most of whom were assigned to district offices. All employees are being trained in relation to the new program.

Many of these new employees are former State and local people who worked with income maintenance or support activities. Planning with States on personnel matters is coordinated on a regional basis through the Regional Commissioners' Offices. Preference in hiring is being given to State and local people displaced involuntarily because of federal administration of the adult categories.

The issues presented here constitute the tip of the proverbial iceberg. They are cited not as an exhaustive review of our planning but merely to convey some feeling about the complexity of the task and our efforts at coping with unique situations.

Fortunately, SSA is an old hand at complex tasks involving new programs. The disability insurance program and Medicare, now so much taken for granted, also required substantial planning.

Although the new program has caused an expansion of facilities and personnel within SSA, it has not required the establishment of an entirely new organization. It is estimated that 60 percent of the aged, who comprise most of those who will be eligible for SSI benefits, are already on SSA records. These people will be able to go to one office for both social security and supplemental security income benefits.

With its added experience and expanded resources, the agency today is even better equipped to administer a program of this type. It has the knowhow and expertise based on successful experience with the social insurance programs; it has a wide-spread, well-staffed field structure already in place; and it has the technology and management techniques and computer capability needed to do the job.

A highly mechanized system does not have to be an impersonal system. The use of computers is not necessarily incompatible with concern for human needs. The same tradition of service for which the Social Security Administration has become known in relation to the social insurance programs will govern the operation of this new program.

In the *Devil's Disciple*, George Bernard Shaw writes: "The worst sin towards our fellow creatures is not to hate them, but to be indifferent to them: that's the essence of inhumanity."

I would like to believe that this new program, with its concern for human needs, emphasizes man's humanity to man.

Mr. Hess is Deputy Commissioner, Social Security Administration.

One Way To Assess Needs

SHARON BISHOP

Several billion dollars worth of Federal, State, and local public and private money is being spent this fiscal year in the provision of social services. For public welfare social services alone Congress allocated $2.5 billion. When added together with funds spent from all sources for aging, youth development, vocational rehabilitation, child development, and economic opportunity programs, the total amount of social service expenditures is substantial—larger, in fact, than the entire budgets of some countries.

Whether or not these expenditures are sufficient to meet the service needs of people in this country or adequate to make an impact on the social problems and disabilities of our society is an issue of current debate. Unfortunately, like many debates on public policy, this one is also being conducted with gaps in the body of relevant information. It is impossible to judge absolutely the adequacy of service programs or expenditure levels without knowing a great deal more about the amount and kinds of service needs among our citizens. No one has demonstrated to everyone's satisfaction that people do, in fact, need social services or that social services can be fully effective for solving individual and social problems.

Social service needs assessments and effectiveness studies are a first step in the justification of service programs. Both, however, are underdeveloped activities, due partly to the traditionally low priority given to research in the social welfare field. As a result, we are just beginning to understand the importance and possibly the necessity of assessing social service needs. We are just beginning to develop the necessary tools and methodologies and to learn how to make maximum use of the information obtained.

The usefulness of needs assessment can go beyond justifying the existence of a program to providing a basis for program planning and budgeting at all levels of government.

Careful planning and management are essential to achieve the most effective and efficient use possible of resources.

All too frequently in the past, the provision of social services was based more on the simple availability of a given resource than on the facts of identified need. Consequently, services often lacked direction, focus, and organization.

With an adequate needs information base and the knowledge of available resources, service programs can be planned in a more logical, rational, and coherent fashion. Priorities for service delivery can be assigned and specific; operational objectives can be set. You can evaluate the program much better if its goal and purpose are clear.

In addition, a clear knowledge of needs and resources enables planners to establish priorities for geographic areas, target client groups, problems, services, and methods of service delivery. For example, a county youth development agency may decide to focus its activities on the three communities with the greatest number of youth offenders. Alternatively, it may set a priority on educational and vocational counseling because the expressed need and anticipated uses are higher for these services than for counseling services of a general, overall character. A public welfare social service director may assign a higher priority to family planning for teenage welfare mothers than for older AFDC mothers, or vice versa, depending on which group has the greater need. An agency may, on the other hand, assign low priority to an area of substantial need such as housing, because the community's resources to meet the need are nonexistent and continued efforts to solve the problem with the existing resources would be an ineffective investment.

In addition, an adequate assessment of needs and resources allows planners to lay out the kind of program objectives that would meet the requirements of prospective clients. Planning staff in a services-to-the-aging program, for example, can determine that the agency can, over the next year, realistically serve 3,000 elderly, providing them with a specific number of home-delivered meals, special transportation services, visiting companions, and arrangements for health care. Setting such specific goals is important for project evaluation. Failure to reach a specific objective will pinpoint an area of poor operational performance. Achieving specific objectives will provide project staff with a sense of accomplishment.

Information on service needs can also be used in the allocation and organization of staff, in decisions on where to locate service facilities, in directing outreach activities, and in developing new programs or service delivery techniques. A needs assessment may, for example, uncover a group of Spanish-speaking AFDC mothers who, as a result of cultural constraints, will not seek out the services they need. As a result of this finding, the local agency could assign a special bilingual outreach worker to inform the mothers of the availability of services and could develop a small program to aid the Spanish-speaking families in the socialization process.

Needs assessments can also be used to justify or substantiate legislative budget requests and as a basis for special grant applications. Presumably, the presentation of hard data in support of a request for money will increase the likelihood of a positive response.

To derive the maximum amount of utilization in planning and management, the data base created by the needs assessment should be comprehensive but focused. The basic parameters of the assessment must be explicit. For example, the population group to be studied should be rigidly defined: a needs assessment could be done for a total community or for one segment of it—the welfare population, the elderly, juvenile delinquents, or any other definable group.

Similarly, the geographic and functional service areas to be covered must be identified. An assessment of the housing needs of the elderly in Pittsburgh is very different from an assessment of all the social service needs of the entire welfare population in Pennsylvania.

Clearly, the more restricted the study, the easier it will be to design and carry out. The potential utility of a highly restrictive study will, however, be more limited than the potential utility of a less restrictive one. One rule of thumb that is useful here is "balanced latitude." To produce valid data and maintain a project of manageable size, the three primary assessment parameters of *population, service,* and *geography* should be balanced, and at least one of the three should be narrowly defined. For example, one could reasonably assess the family planning needs of AFDC mothers in Mississippi or all service needs, including family planning, for AFDC mothers in Jackson, the State capital.

Two of the critical issues that must be addressed in designing a needs assessment are determining how a service need will be defined and determining who will identify the presence of a need. The development of data collection instruments and methodologies will depend on the approaches taken to these two problems.

Defining a social service can be difficult, but defining a social service need is even more difficult. One approach is to develop standards of some kind and then measure the status of individuals in relation to those standards. In these terms, a need exists wherever an individual's status does not meet an established standard. The distance between the individual and the standard is the measure of the severity of the need.

Housing is an example for which standards could reasonably be employed. Indoor plumbing and electricity are generally accepted as two of the standards for adequate housing. A family with outdoor privies and no electric lights can be said to be living in substandard housing and to have a need for adequate housing. Setting standards, however, involves value judgments that can be loaded with danger for social welfare research. Almost everyone may agree on the criteria for adequate housing, but a consensus on standards for a less tangible subject, like housekeeping practices or family functioning, would be more difficult to reach.

How should the need for family planning or consumer education services be determined? What is the standard for

family size or money management? Does the existence of seven children indicate a need for family planning? Statistical norms are often useless for establishing standards. Most Americans, for instance, are poor managers of their personal finances.

Another problem with setting standards is that the establishment of ideals generally entails the imposition of cultural, moral, or religious values. Fear of pressure for social conformity to standards that may not represent universal values, with an attendant loss of individuality and freedom, makes research based on standards unpalatable for many.

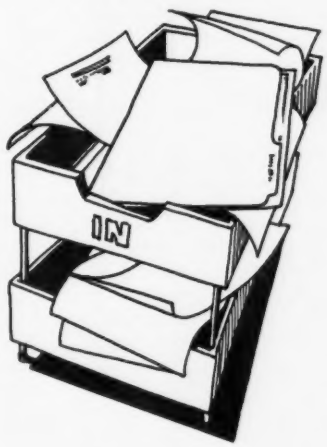
One possible solution to the dilemma of standards and values relates to the question of who will determine the existence of needs? The issue of imposing values on people might be avoided if the individuals with potential service needs were responsible for needs identification. A mother with two children, for example, might express a need for family planning although one with five children might not.

Allowing recipients to identify needs, however, produces two areas of concern. One problem is that an individual might identify needs he does not have; the second is that he might fail to identify needs he *does* have.

Without the use of objective criteria, the identification of "need" can become almost synonymous with the identification of "want." A person may, for instance, want day care services simply to get rid of the kids for a few hours a day, or may express a need for improved housing even though his present housing conditions are adequate. But publicly funded social services must be directed to the individuals with the greatest needs, not to those who most readily express wants.

Similarly, the individual with the potential need for service may not be able or willing to identify that need. This reluctance to express need may be characteristic of certain age groups—the very young and the very old—or of people with such special problems as drug abuse, alcoholism, or child neglect. The difficulty that a child welfare worker encounters in determining whether a particular situation is so harmful to the life and well-being of a child that it warrants involuntary protective services is multiplied ten-fold when a research project attempts to determine the extent of child abuse in a specific community. Yet, somehow, needs must be determined. The question is who should determine them—the people in need or program planners?

An alternative to the "standards" approach of defining need is available in the form of a goal/barrier model. The



goal/barrier approach assumes that most of the social service client population can be categorized according to a small number of identifiable goals, such as self-support. When an individual is unable to reach or maintain his goal due to some personal impediment (*e.g.*, lack of job skills), he can be said to have a barrier. If that barrier is not currently being addressed through the provision of a service (*e.g.*, job training), then a service need can be said to exist. This approach requires development of a range of acceptable goals and their corresponding barriers and the establishment of criteria which can be used in research definitions. The problems encountered in such an effort, however, are similar to those that arise in developing standards.

There is no immediate, all-purpose solution to the issues of how to define social service needs and who is to identify them. The needs assessment designer must work out a compromise that will afford the best possible mix of validity, reliability, and practicality. The extent to which the assessment designer can identify the impact of his compromise and allow for it in the analysis and interpretation of his findings will measurably improve the quality of the results.

Research methods and instruments used in needs assessment are interrelated with the questions of how needs will be defined and who will define them. Choice of research methods and instruments can determine the "how" and "who" of needs assessment or, alternatively, can be determined by them.

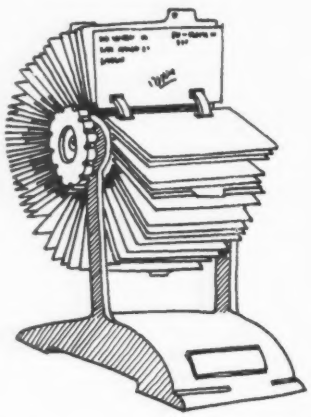
Several different methodologies for assessing social service needs exist. They can be categorized as being based on either primary or secondary data sources. Primary data sources are people who possess the characteristics being studied. Secondary sources are places (records, statistics, etc.) where one could learn about those people without going near them.

The most common primary source methodology is the population survey using statistical sampling and a structured questionnaire administered by an interviewer. The sampling methodology and the level of sophistication to be used will depend on the characteristics and accessibility of the population to be studied. The size of the sample can range from 100 to 1,500 individuals or households and should be related to the number of variables in the questionnaire, rather than the size of the total population being studied. The questionnaire should be logically constructed, with precoded answers to facilitate computer analysis. It should require approximately 35-45 minutes to administer. An inverse proportional relationship exists between the scope of the study and the depth of the information that can be obtained with a questionnaire. The narrower the focus of

the study, the more detailed the data will be. Use of population surveys using statistical sampling and a structured questionnaire administered by an interviewer is the costliest kind of needs assessment methodology in terms of time and money, but it is also the one that is thought to produce the most reliable and comprehensive information.

Two other methods for surveying the population directly are the mail-out questionnaire and the professionally administered diagnostic interview.

The mail-out questionnaire method is less costly than the interview population survey but relies on the interpretation of the individual respondent and his willingness to return the questionnaire. Mail-outs have a reputation for a low return rate (25 percent), although some welfare agencies have had surprisingly good results with them. In addition to the risk of a low



volume of returns, mail-out surveys run a substantial risk of bias because the respondents do not represent a random sample of a population but rather a self-selected group—those who choose to return the questionnaire.

The professionally administered diagnostic interview uses the knowledge, experience, and interviewing skills of a social service professional instead of a structured questionnaire to assess the needs of individuals. Using a person, rather than an impersonal instrument, as a data collection system, however, may introduce uncontrollable subjective bias into the results of a survey.

Methodologies for secondary data sources include the use of key informants, existing statistics or social indicators, and case records.

Key informants are those individuals in a community who are considered knowledgeable about the needs of the population in question. Studies based on the views of key informants can be very difficult to design, and their findings are better characterized as opinion than fact.

Success in using existing social statistics or social indicators depends on the availability of pertinent data. Social indicators are not yet well developed. The best statistics in some communities are from the 1970 Census, which will become progressively outdated. At best, an analysis of existing statistics will present some indication of potential service needs. It is unlikely, however, to provide sufficient information for service program planning purposes. Success in using case records as a data source also depends on the amount and kinds of information contained in the case records. If the right information is available in the records, a case record analysis can produce a fairly good picture on the needs of an agency's current service population. The major problem is whether this current service group is representative of the larger group that is not being served but is eligible and needs services. None of the secondary sources of data appear to be ideal, but some of the deficiencies in secondary source data are balanced out by the ease of using them and their relatively low demand of cost and effort. Combining several secondary sources for the total needs assessment may be worthwhile in order to counterbalance the weaknesses of individual secondary source data. Using secondary data sources resolves the problem of *who* identifies a need, but it increases the problem of *how* to identify a need.

Along with a basic conceptual framework and methodology, a needs assessment plan should include all the particulars of sample size, sampling methodology, data collection techniques, tabulation forms, analysis methods, and the data collection instrument. The importance of thorough pretesting cannot be overemphasized; the pretest should include not only the instrument but also the planned tabulation and analysis.

Essentially, the design of a needs assessment project will be based on the intended utilization of the results, the scope of the study (geographic area, population, and service area), the definition and understanding of need, the methodology chosen, and practical administrative limits.

Practicability is an important, almost overriding, concern. The assessment must be planned within the limits of available resources, staff, and money. An overly ambitious, inadequately executed assessment may be worse than none at all. It is possible, however, to conduct a well designed, focused assessment with minimal cost and using existing agency staff. Needs assessment planners must also keep in mind that assessment findings must be eminently usable by other agency personnel in order to justify the investment.

The art of assessing social service needs is still in its infancy. Administrative commitment to conducting and utilizing needs assessments is essential if technical knowledge and skills are to be developed further. As the quality and complexity of the data gathered through needs assessment increases, comparably sophisticated planning and management tools will be developed to use the information. The long-term benefit of needs assessment to the administrator will be service programs that are more manageable and have greater client effectiveness.

Ms. Bishop, an associate with Booz, Allen, and Hamilton Public Administration Services, is project manager of an SRS-funded study to develop alternative methodologies for assessing social service needs and resources.

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Publications and Films

The Editors of the SOCIAL AND REHABILITATION RECORD regularly receive notification of the release of new publications and films of interest to readers.

Each issue of the RECORD will carry a selected list of these publications and films with brief discriptions of their contents.

Please address all inquiries and requests to the addresses given in this listing.

Vocational Rehabilitation: Profession and Process. John G. Cull, Ph.D. and Richard E. Hardy, Ed.D., editors. Charles C Thomas, 310-327 East Lawrence Ave., Springfield, Ill. 62703. 547 pages. $18.50.

In this collection of papers on vocational rehabilitation, the emphasis is placed on the counseling process and the individuals it involves. Many of the contributors, all professional leaders in the field of vocational rehabilitation, were themselves counselors.

The book looks first at the history and philosophy of rehabilitation: It then discusses the rehabilitation practitioner, the services he provides, the counselor's work settings, the clients, and other professionals with whom he works.

Readings on Deafness. Douglas Watson, Ph.D., editor. Deafness Research and Training Center, New York University School of Education, 80 Washington Square East, New York, N.Y. 10003.

The 15 articles collected for this publication represent a "repudiation of practices and thinking which have historically restricted deaf people from realizing their full human potentials within the context of that 'silent minority' known as the deaf community."

The contributors present both professional and personal views in papers dealing with the experience of deafness, different approaches to deaf education, improvement of rehabilitation service delivery, and the deaf community itself.

Public Assistance-Vocational Rehabilitation Policies & Practices: Resources for Training. ICD Research Utilization Laboratory, 340 East 24th St., New York, N.Y. 10010. 128 pages.

Guidelines designed to strengthen State-Federal relations in answering training needs and in providing joint services for the rehabilitation of disabled public assistance recipients are published in this SRS-supported project report.

Prepared for State administrators, staff, and program development personnel, directors of demonstration projects, and other State officials this information concerns federal policies and practices as well as State and local activities in the area of PA/VR cooperation.

Contemporary Field Work Practices in Rehabilitation. John G. Cull, Ph.D. and Craig R. Colvin. Charles C Thomas, 301-327 East Lawrence Ave., Springfield, Ill. 62703. 323 pages. $16.75.

A text in rehabilitation field work is presented here as a way to facilitate integration of academic course work with the field work experience. The book exposes counselor trainees and rehabilitation students to a broadened training approach, using exercises in field work and in addition, to modern practices and trends in vocational rehabilitation counseling.

Research and Training Center (13) University of Arkansas, Arkansas Rehabilitation R&T Center, Fayetteville, Ark. 72701.

The following research reports have been received from RT-13: *Client-Counselor Interactions, Patterns of Service, Client Outcome,* 38 pages; *Rehabilitation Counselor Behavior and Client Short-Term Personality Change,* 48 pages; *The Relationship of Client Initial Psychological Functioning, Rehabilitation Counseling Behavior, and Counselor-Client Characteristics,* 53 pages; *Client Demographic Characteristics and Psychological Status at Initiation of the Rehabilitation Process,* 16 pages; *Counseling Interview Behavior of Empirically Derived Sub-Groups of Rehabilitation Counselors,* 90 pages; *Empirically Derived Rehabilitation Counselor Subgroups and Their Biographical Correlates,* 41 pages; *A Review of the Literature on the Prediction of Rehabilitation Client Outcome and the Development of a Research Model,* 59 pages; *Arkansas' Juvenile Offenders: A Profile,* 28 pages; *A Review of Factor Analytic Studies: 1941-1970,* 16 pages; *Analysis of Rehabilitation Counselor Interview Subrole Behavior,* 18 pages.

International Catalog of Aids and Appliances for the Visually Impaired. American Foundation for the Blind, Inc. 15 West 16th St., New York, N.Y. 10011. 214 pages. $2.

Suggested as a "source of guidance" to blind individuals and agencies serving the blind, this publication presents data on aids and appliances for the visually impaired. Included in the product descriptions are the names and addresses of manufacturers and distributors from whom detailed ordering and shipping information may be obtained.

The aids are listed in 28 categories which include: braille duplication, writing aids, talking books, mobility, low vision aids, educational aids, recreation, home management, and vocational aids.

School Intervention. William L. Claiborn, Ph.D., and Robert Cohen, Ph.D., editors. Behavioral Publications, 2852 Broadway, Morningside Heights, New York, N.Y. 10025. 265 pages. $7.95.

Professionals and workers in the fields of mental health and education are now moving toward a closer understanding and cooperation designed to serve the mental well being of school children. A response to this movement in the educational system from the First Annual Symposium on Current Issues in Community-Clinical Psychology held at Maryland University in March 1971, is presented in this volume of papers.

Directed to educators and mental health practitioners, the book considers the philosophy, social responsibility, impact, goals, problems, and approaches involved in the promotion and integration of an active, professional mental health concern in the schools.

Childhood Learning, Behavior & the Family. Louise C. Traichert, M.D. Behavioral Publications, 2852 Broadway. Morningside Heights. New York, N.Y. 10025. 112 pages. $7.95.

The "neurodevelopmental-family approach" to child psychotherapy is considered in this publication. Such a therapy method combines the disciplines of child development and family therapy in order that child and family be viewed and treated as an integral unit. The learning, behavior, and overall communication problems of children are presented in the book which can be used as a handbook for pediatricians, psychiatrists, psychologists, family therapists, nurses, teachers, and social workers.

Health Careers Guidebook. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 166 pages. $2.25.

Prepared by the National Health Coun-

cil, the Manpower Administration of the Dept. of Labor, and the National Institutes of Health of DHEW, this third edition of *Health Careers Guidebook* answers a contemporary need for such vocational and health service information.

Designed to aid and interest students, parents, and counselors in the developing health professions, this document describes educational requirements, costs, future training and related career prospects for each occupation. Also included is an extensive referral list of organizations which may supply more detailed information on particular health field opportunities.

Compendium On Workmen's Compensation. Marcus Rosenblum, editor. Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. 317 pages. $3.45.

Prepared under the auspices of the National Commission on State Workmen's Compensation Laws, this publication surveys the field of workmen's compensation. Examined are: the economic cost of industrial injuries, the development and objectives of workmen's compensation, present programs, 12 major aspects of the existing U.S. system, and various policy and reform alternatives.

Films

Listen. 16 mm. Color. Sound. Total Communications Laboratory, Western Maryland College, Westminster, Md. 21157. Rental $15.

A documentary on hearing loss, its causes, its psychological meaning, and what can be done to cope with the problem. In parts of the film sounds are filtered to approximate how they are actually heard by persons with different kinds of hearing losses such as that of a profoundly deaf boy, a young female vocalist made hard of hearing by continued exposure to hard rock music, and a psychiatrist with otosclerosis.

Listen is for use with the general public and persons with hearing losses and their families. It is available with or without captions and provides an excellent orientation to the problem of hearing loss in today's society.

Mimi. 16 mm. Black and white. Sound. 12 min. Billy Budd Films, Inc., 235 East 57th St., New York, N.Y. 10022. Sale, $125. Rental, $15.

Mimi is the true story of a young woman coping with her own disability (paraplegia) as well as others' inability to respond to her in a normal way. *Mimi* touches on stereotypes, pity and condescension, architectural and psychological barriers, education and employment, fantasy versus reality, and frustration and dropping out.

Serving Students With Special Needs. Multi Media Office, Mount San Jacinto College, P.O. Box 248, Gilman Hot Springs, Calif. 92340.

The following multi media presentations consist of a tape (running time indicated with each title); 35 mm, color, filmstrip; worksheet; and post-test. Each kit costs $14. Tapes are available in both open reels and cassettes, so please specify type desired. Use title and number in placing orders.

The strips are:

Resources And Methods In Teaching Visually Handicapped Students (VT 40ph). 24 min.; 62 frames.

Illustrates shop-orientation of blind students; describes aids and devices to facilitate instruction; and provides an overview of agencies, specialists and organizations which are prime resources for instruction of visually impaired students.

Resources And Methods In Teaching The Hearing Handicapped (VT 41ph). 20 min.; 49 frames.

Describes special learning problems of hearing impaired students; illustrates interpreting situations; and examines services and resources to improve instruction.

The Teacher And Agencies For Pre-Training Development (VT 42ph). 16 min.; 37 frames.

Identifies five work-related evaluation procedures used to determine handicapped person's pretraining needs; then examines vocational teachers' roles in pretraining evaluation and deficit remediation.

Teacher And Agency Interaction In Training And Placement (VT 43ph). 21 min.; 50 frames.

Describes functions of nine agencies which provide services to handicapped persons. Examines relationships a vocational teacher might utilize to increase the probability that a physically impaired student can succeed in training and placement.

Physically Handicapped Workers In Service Occupations (VT 51ph). 21 min.; 43 frames.

Case studies of physically impaired workers in service occupations. The teacher is asked to evaluate each subject's physical demand capabilities (using D.O.T. classifications), and the suitability of the person's present employment.

Physically Handicapped Workers In Business and Distributive Occupations (VT 52ph). 21 min.; 43 frames.

Case studies of physically impaired workers in business and distributive occupations. The teacher is asked to evaluate each subject's physical demand capabilities (using D.O.T. classifications), and the suitability of the workers present employment.

Physically Handicapped Workers In Trade, Technical And Industrial Occupations (VT 53ph). 21 min.; 43 frames.

Case studies of physically impaired workers in trade, technical, and industrial occupations. The teacher is asked to evaluate each subject's physical demand capabilities (using D.O.T. classifications), the the suitability of his present employment.

Classroom Organization To Teach The Physically Handicapped (VT 70ph). 20 min.; 40 frames.

Reviews common problems which may occur when students with obvious physical differences are brought into regular classes. Ways to prevent or solve such problems are suggested.

Films in Mental Retardation: A Select Annotated Bibliography. Kevin B. McGovern and Esther R. Brummer. Rehabilitation Research and Training Center in Mental Retardation, University of Oregon, Eugene.

Presented in this monograph is a listing of forty films which have been used in the past 5 years at the University of Oregon Research and Training Center to supplement training programs for personnel working with the mentally retarded.

The paper contains: descriptive summaries of each film, a list of the film distributors, and a subject index.

Prediction, Programming and the Language Retrieval Unit. 16 mm. Color. 15 min. Ohio Dept. of Health, Division of Chronic Diseases, P.O. Box 118, Columbus, Ohio. 43216. Sale $15. Inquire for rentals.

A demonstration device designed for professionals and students in speech sciences, the film depicts the potentialities of language therapy as it is and may be further used in treating aphasic adults.

Making Knowledge Useful

THOMAS E. BAKER and EDWARD M. GLASER

■ In Virginia, Paul Bassett has helped rehabilitation counselors do their own diagnostic psychological testing to determine eligibility of clients who may be mentally deficient.

■ In New Jersey, Adrian Marinelli spearheaded a program to get former welfare clients employed as rehabilitation workers.

■ In Utah, Ralph Gant held a rehabilitation seminar for 82 local employers and encouraged them to hire disabled persons.

■ In California, Morgan Vail worked to obtain a part-time resident rehabilitation aide for a sparsely-populated area of the State.

■ In Alabama, Homer Jacobs provides special services to handicapped homemakers through a series of television shows and a newsletter.

These men have more in common than just dedication to provide more and better rehabilitation services for handicapped people, although dedication itself would be enough. They are part of a unique, nationwide network of professionals called Research Utilization Specialists (RUS) whose chief mission is to identify promising research findings or other new knowledge that can help improve rehabilitation services.

Massachusetts, New Jersey, Virginia, Alabama, Wisconsin, Texas, Missouri, Utah, and California are the nine States that have experimental RUS projects attached to their vocational rehabilitation agencies. Since 1969, each RUS has been working to identify service needs that can be met, at least in part, by what researchers have learned, or by what practitioners in other settings have found to be useful.

The experimental demonstrations are funded principally through SRS, with the State agencies contributing at least 10 percent of project cost. Initiated in 1969 as 5-year grants, they are testing the value and viability of this kind of an approach to increasing the use of rehabilitation research.

Available Resources

In grappling with the complex problems of providing rehabilitation services to handicapped and socially disadvantaged people, SRS has funded R&D studies throughout the U.S. About 2,200 such projects have been completed since the 1950's, and $21 million a year is spent in supporting rehabilitation research. Many have yielded or will produce knowledge that is of practical use in helping clients return to work. Principles, specific practices, and technological products emerge from these studies—and from work sponsored by other funding sources—to form a rich resource pool. Moreover, rehabilitation facilities throughout the Nation are constantly devising and trying out new programs and procedures; some of these are good enough to be used or adapted in other settings.

The Challenge

Unapplied knowledge might as well be undiscovered. The sad fact is that many research reports lie unread on bookshelves, and many others never reach the people who could apply them in their day-to-day work. Counselors and administrators often complain that the research reports they do look at are obscurely written: they seem irrelevant to firing-line problems.

Sheer volume can be a great hindrance to the counselor or program director who wants to improve client services, administrative procedures, or performance evaluation. Faced with either a laborious literature search or "seat-of-the-pants" action, many professionals choose the latter.

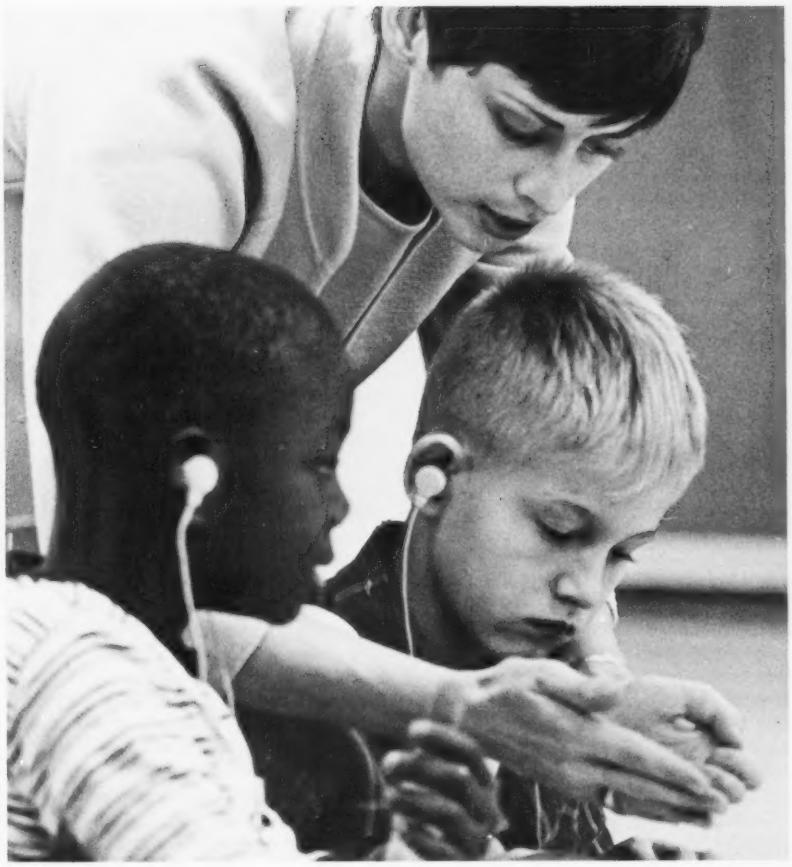
All this means that there is much in the rehabilitation research literature—not to mention innovative practices in other settings that may be equally hard to identify—that is not immediately accessible or usable at the service delivery level. Thus, it is the RUS's task to identify, retrieve, and translate promising new knowledge so that it can be used to improve VR agency practice and procedures. Each of the RUS projects has a number of ways to "get the word out"—newsletters, information dissemination systems, and special projects designed to introduce innovations in a given area of rehabilitation service.

Some Special RUS Subprojects

The efforts already mentioned are only a few of the numerous special programs the RUS's have initiated since 1969. As a representative sample, these five and one from each of the remaining project States are presented here.

Job Placement Innovation. In Massachusetts Ed Tully organized and conducted an inservice training program for counselors on job placement. Three teams of counselors participated in a special conference on placement. Later, they were given systematic coaching by experts, had regular face-to-face meetings with employers, and made personal visits to employment sites. An evaluation questionnaire indicated program success.

The RUS's thorough familiarity with placement literature permitted him to select a number of "best practices" that were new to the agency. Understanding utilization processes, he organized the project in ways designed to increase counselor and administrator involvement and enthusiasm. Participants' commitment



was gained by inviting them to help plan and carry out program activities.

Use of Paraprofessionals. The N.J. RUS spearheaded a program to employ former welfare clients as rehabilitation workers in an innovative, job-upgrading program. At the end of 2 years, 26 paraprofessionals were working. By April 1973, eight of them had qualified to become full-fledged rehabilitation aides.

To get this program going, RUS Adrian Marinelli reviewed the research literature, wrote a position paper to convince agency decisionmakers that the project was worthwhile, and prepared an application for SRS demonstration funding, which was approved in July 1970. He also worked with field staff and with the program's supervisor to help overcome counselor resistance to working with paraprofessionals. A number of counselors now have requested aides of their own. Eight of the trainees have been upgraded, and 70 percent of the original aides are still on the job after 2 years.

Psychological Testing. The Virginia RUS wrote a proposal and selected a battery of tests for use by rehabilitation counselors in diagnostic testing. Previously, testing had to be referred to a psychologist, and there had been backlogs of clients needing testing. The agency accepted the RUS's proposal, selected a "test-kit" for counselors from those assembled by the RUS, and instigated direct counselor testing. According to the agency, substantial savings have resulted from this effort.

Handicapped Homemaker Program. The RUS is one of a small group of persons who have developed homemaker training programs for disabled persons in Alabama. Homer Jacobs has been especially influential through his contribution of research findings from other States.

Activities of the Handicapped Homemaker Program include a newsletter and a television series about how handicapped people can live more independently in their homes. These have enabled thousands of handicapped persons to learn of and try out new ideas for simplifying everyday activities in their homes. Two rehabilitation facilities in the State also provide direct training services.

The RUS has provided ideas from the research literature for this effort, helped to organize it, and has participated directly in program activities. Funds from the RUS project have been used to finance parts of the program.

Services to Alcoholics. The Wisconsin RUS, Dr. Bill Sather, worked with staff at the DePaul Rehabilitation Hospital in Milwaukee to develop an industrial alcoholism program. It combines early case identification and innovative treatment of employed persons who are in the early stages of alcoholism. Emphasis is placed on early intervention at a time when most clients are highly motivated to become involved in treatment and after-care to assure their continued employment. Preliminary findings suggest that most clients served by the project are staying dry and performing well in their jobs.

Transportation Problems of Handicapped People. Both literature review and direct analysis of existing situations are being used by Randy Scott, the Texas RUS, to develop plans for better resolution of handicapped people's transporta-

tion problems. He is trying to discover what services now are available, how they could be coordinated better through interagency cooperation, and how to increase agency and community support for further special transportation programs, such as driver training for the handicapped. An interagency conference is being planned to begin working towards attainment of these goals.

Project Rule. Research Utilization through Learning Experience (RULE) was conceived of and developed jointly by the Missouri RUS and the director of the Region VII Regional Rehabilitation Research Institute. Rehabilitation professionals throughout the region visit selected facilities to observe especially good methods of service delivery. After their project-supported observation, the visitors report to RULE what they learned and how they intend to use the new knowledge. The Missouri RUS, Erwin Buchanan, worked with the RRRI director and others on the grant proposal to obtain SRS funding.

Employers' Seminar in Utah. A seminar for employers oriented them to rehabilitation services and encouraged them to hire disabled people. Eighty-two persons participated, representing both small and large firms. The RUS conducted a literature review and made contact with other State agencies to prepare for this seminar. Initial employer reactions have been very favorable.

Resident Representative Program. The California RUS drafted a proposal, negotiated with SRS central office staff, and developed an evaluation design for an experiment in which a part-time resident rehabilitation paraprofessional serves a sparsely populated section in the Sacramento area. He reviewed literature relevant to this idea, helped develop a training program, and got some graduate students to assist in the evaluation. The resident representative will provide several ongoing services—testing, followup, taking of applications, etc.—to rehabilitation clients now served only intermittently by an itinerant counselor. This project should extend the range of services and reduce the time needed to deliver them.

These are by no means the only efforts the RUS's are making to apply new knowledge and facilitate change in their State VR agencies. Many others are in operation: a behavior modification training effort and community involvement program in Virginia, hiring an inhouse medical examiner and implementing a model or experimental district office program in California, a graduate student internship in research utilization in Utah, a proposed NASA-SRS rehabilitation research utilization laboratory in Texas, a special PA/VR training program in Missouri, and more.

Evaluating the RUSs

Unlike such strategies as mailing out journal articles, abstracting of them, or indexing the research literature, the RUS concept presupposes that mere information availability is not enough. Research utilization occurs when people are *motivated* to change, when they sense a need to improve practice and see certain research findings as possibly helpful in meeting that need. Psychological variables thus become very important, so that the RUS can be seen as a change agent, motivating service delivery professionals to use new knowledge in innovative ways.

Does the RUS model work? Is the RUS a good, workable supplement to literature indexes and clearinghouses for facilitating the utilization of research? The above case examples suggest that some productive activities are underway, but more complete answers to these questions require systematic study. For this reason, SRS awarded a 3-year contract to Edward Glaser & Associates of Los Angeles to evaluate the nationwide RUS demonstration program.

During the 1st year, portraits of the nine RUS projects were developed, detailing *what* the projects have been doing and *how* they have been doing it. RUS project progress reports, VR agency annual reports, RUS-generated newsletters, and many other documents were read to develop an on-paper understanding. Then followed a 4- to 6-day visit in each project State interviewing the RUS and in some cases the VR administrator and counselors involved in RUS activities. In addition, two short survey questionnaires were circulated about the project to random samples of VR agency personnel in each of the nine states.

In the upcoming year of evaluation, we hope to acquire evidence about the specific impact of each RUS activity on the quality of rehabilitation services provided. At a time when *accountability* is a key concern in all the human services, these projects need to be examined in terms of measurable indicators of success, such as increased number of cases closed, dollar savings, or improved quality of services provided.

Toward the end of the 3rd year, we hope to hold a nationwide conference of rehabilitation professionals and others who may be interested in examining the RUS model more closely. By that time, demonstration funding for the RUSs will have terminated (though some of the projects seem likely to be picked up by their State agencies for continued existence). The results of our evaluation can be used to help decide whether the RUS concept is a worthwhile one to apply in other State VR agencies, or in other social service delivery systems.

We hope to identify during our evaluation study some of the particular RUS strategies that seem to make this "human linking pin" concept work. From this kind of study, we may be able to learn a lot about how to effectively bridge the gap between researchers and practitioners in rehabilitation—and how to facilitate the actual use of new knowledge in improving service delivery.

Both Mr. Backer and Mr. Glaser are associated with the Human Interaction Research Institute of Los Angeles. The Institute is conducting a national evaluation of the nine research utilization specialists demonstrations that are presently underway.

Research & Demonstration

In some instances recent project reports can be obtained from the grantee (addresses given below). When the report is not available from the grantee, it may be purchased from the National Technical Information Service, Springfield, Virginia 22151. Remittances should accompany orders; prices are $3 for hard cover and $.95 for microfiche copies.

MATCHING JOB AND WORKER CHARACTERISTICS WORK SUPPLEMENT FOR THE AGED. (RD 55050) Human Resources Center, Albertson, N.Y. 11507. 78 pages.

AREA YOUTH WORK DEMONSTRATION PROJECT INVOLVING INDIGENOUS PERSONNEL. (RD 55125) Philadelphia Dept. of Public Welfare, Rm. 800, City Hall Annex, Philadelphia, Pa. 19107. 63 pages.

REHABILITATION BIOMEDICAL ENGINEERING: ORTHOTICS DESIGN. (RD 55117) Krusen Center for Research and Engineering, Moss Rehabilitation Hospital, Philadelphia, Pa. 19141. 62 pages.

PROJECT STAR (SERVING TO ADVANCE REHABILITATION). (RD 55061) National Urban League, 55 East 52nd St., New York, N.Y. 10022. 156 pages.

PROJECT STAR "COOKBOOK." (RD 55061) National Urban League, 55 East 52nd St., New York, N.Y. 10022. 62 pages.

A COMPREHENSIVE FACILITY PROGRAM FOR MULTIPLY HANDICAPPED DEAF ADULTS. (RD 55216) Arkansas Rehabilitation Research and Training Center, West Avenue Annex, 346 North West Ave., Fayetteville, Ark. 72701. 74 pages.

THE EVALUATION OF VOCATIONAL DEVELOPMENT OF DEAF YOUNG ADULTS. (RD 55065) Lexington School for the Deaf, 30th Ave. and 75th St., Jackson Heights, N.Y. 11370. 84 pages.

THE REHABILITATION DECADE: THE FIRST YEARS, 1970 - 1972. (RD 55058) Rehabilitation International, 219 East 44th St., New York, N.Y. 10017. 116 pages.

SERVING DEAF ADULTS: DEVELOPMENT OF INNOVATIVE PATTERNS OF COMMUNITY SERVICE FOR THE ADULT DEAF. (RD 55089) The National Association of Hearing and Speech Agencies, 814 Thayer Ave., Silver Spring, Md. 20910. 132 pages.

TO EVALUATE THE EFFECTIVENESS OF ACHIEVEMENT MOTIVATION TRAINING FOR MENTAL PATIENTS BEING REHABILITATED TO THE COMMUNITY. (RD 55122) Pennsylvania State Univ., University Park, Pa. 16802. 46 pages.

DEVELOPMENT OF ORTHOTIC SYSTEMS FOR THE QUADRIPLEGIC PATIENT. (RD 55207) Engineering Design Center, Case Institute of Technology, Case Western Reserve Univ., Cleveland, Ohio. 44106. 181 pages.

MOBILE UNIT TO PROVIDE VOCATIONAL EVALUATION FOR HANDICAPPED CHILDREN. (RD 3225) Board of Education of Baltimore County, Towson, Md. 21204. 113 pages.

PREDICTION OF CLIENT PERSONALITY CHANGE DURING THE REHABILITATION PROCESS. (RD 55219) Arkansas Rehabilitation Research and Training Center, Univ. of Arkansas, Fayetteville, Ark. 72701. 42 pages.

LINEAR VS. BRANCHING STRUCTURES IN THE PRESENTATION OF ACCULTURATIVE MATERIALS. (RD 55175) Dept. of Psychology, Univ. of Illinois at Urbana-Champaign, Champaign, Ill. 61820. 31 pages.

RESULTS OF R&D PROJECT FOR YOUTHFUL DRUG ABUSERS INTEGRATING VOCATIONAL REHABILITATION AND PSYCHOTHERAPY. (RD 3580) Alcohol and Drug Section, Mental Health Division, 309 SW Fourth Ave., Portland, Ore. 97204. 122 pages.

INFLUENCE OF SPORT ACTIVITIES ON REHABILITATION OF PARALYTIC SUBJECTS. Ralph Spira, M.D., editor. Assaf Harofe Hospital, The University of Tel Aviv, Medical School, Tel Aviv, Israel.

This research was supported by SRS grant Isr 22-64.

FULL EMPLOYMENT FOR THE MENTALLY RETARDED. (RD 55244) Jewish Employment and Vocational Service, 1727 Locust St., St. Louis, Mo. 63103. 151 pages.

PROPRIETARY ITEMS AND REHABILITATION WORKSHOPS. (RD 55278) Phoenix Products, Inc., 6901 Beck Ave., North Hollywood, Calif. 91605. 46 pages.

COUNSELING AND COMMUNITY SERVICES CENTER FOR THE DEAF. (RD 55110) Pittsburgh Hearing Society, 313 Sixth Ave., Pittsburgh, Pa. 15222. 61 pages.

THE STALLWORTH PROJECT—PLANNING A COMPREHENSIVE REHABILITATION CENTER—NEW TRENDS IN REHABILITATION CONCEPTS: SERVICE, EDUCATION, AND RESEARCH—IMPLICATIONS FOR LONG-RANGE PLANNING AT VANDERBILT UNIVERSITY MEDICAL CENTER. (RD 55166) Vanderbilt School of Medicine, Nashville, Tenn. 37203. 227 pages.

INTERNATIONAL RESEARCH SEMINAR ON VOCATIONAL REHABILITATION OF THE MENTALLY RETARDED. (RD 55092) American Association on Mental Deficiency, 5201 Connecticut Ave., N.W., Washington, D.C. 20015. 380 pages.

REHABILITATION OF PATIENTS WITH CHRONIC RENAL FAILURE BY MEANS OF HEMODIALYSIS AND RENAL TRANSPLANTATION. (RD 2966) The Johns Hopkins University School of Medicine, Baltimore, Md. 21205. 31 pages.

GUIDELINES FOR REHABILITATION CENTERS FOR DEAF INDIVIDUALS. (RD 55334) National Association of the Deaf, 905 Bonifant St., Silver Spring, Md. 20910. 21 pages.

EFFECTIVE VOCATIONAL GUIDANCE OF THE ADULT DEAF. (RD 55328) Oregon State Board of Control, Salem, Oreg. 97310. 302 pages.

PSYCHOLOGICAL ASSESSMENT OF PATIENTS WITH BRAIN INJURY. (RD 55299) University of Oregon, Eugene, Ore. 97403. 179 pages.

GUIDELINES FOR PLANNING POST SECONDARY TRAINING PROGRAMS FOR THE DEAF WITHIN EXISTING COMMUNITY JUNIOR COLLEGES. (RD 55224) Delgado College, 615 City Park Ave., New Orleans, La. 70119. 116 pages.

Project Studies Military Youth

CHARLES S. CHANDLER

Life can be difficult for children in military families. As these families move from base to base, many youngsters are not able to make new friends easily. In school they frequently become behavior problems, adjusting poorly and unable to compete in regular classrooms.

We can expect an increase in the movement of military families, with all the attendant pressures of adjustment. Of some special interest is the question of how well prepared are the social service agencies in those areas close to military bases.

An SRS-funded project in Beaufort County, S.C., set out to determine what makes troubled military youngsters different from other problem children and whether they need special attention. The study was to contribute to a model for a possible nationwide network of rehabilitation services.

We found that these youngsters do indeed have emotional and personality disorders. The study established that any vocational rehabilitation efforts to help them should be "two track" programs—one designed for military dependents, the other for young civilian clients.

Vocational rehabilitation programs for these youths are virtually nonexistent, and when they do exist, they are usually geared to serve civilian children with very different problems.

In 1967, the school superintendent at the Marine Corps Air Station in Beaufort County began looking for help for problem youngsters on the base. There was no local program suitable for 14- to 18-year-olds—either civilian or military.

The S.C. Vocational Rehabilitation Department had been asked from time to time to help. But its hands were tied in the past by laws limiting services to the physically disabled and to persons of working age. However, legislative changes and additional revenues made it possible for the department to launch the Beaufort project in 1969.

In many ways, Beaufort County is typical of communities adjacent to large military installations. It is predominantly rural and remote from metropolitan areas.

The needs of Beaufort's poor were an added impetus for establishing the VR program. State and federal support was available for treating and feeding the poverty stricken, but little attention had been paid to young people with rehabilitation potential.

The lack of rehabilitation resources also was typical of areas where military families might be stationed. Even in communities where services are available, the very nature of a mobile military life often discourages parents from seeking aid. The families don't become aware of community services in time to take advantage of them. Or, if they do apply for aid, they may be placed at the bottom of a long waiting list and be transferred to a new base before they become eligible. Even when a military child is enrolled in service programs, his family may not remain in the area long enough for effective results. Rarely is provision made for a comprehensive report on the child's problems and progress to follow him to rehabilitation authorities—if they exist—near the next base.

In Beaufort, the project concentrated on researching and defining the special problems of military youngsters. Earlier researchers had concluded that a child's stability and environmental ties were disrupted by frequent family relocations and that separations and reunions give rise to their own special brand of tension and anxiety.

The tendency for a father to carry over the totalitarian and antidemocratic disciplinary measures of the military to his family life was known to breed problems, as did the effect of frequent absences of a father figure. Young children exhibited increased psychopathology when their fathers were away.

A total of 464 youngsters were referred to the program during its 3-year lifespan, approximately 40 percent of them from military families. Most of the youngsters came from Beaufort's junior and senior high schools and were referred by school officials. Social service agencies, local physicians, and youngsters already participating referred the others.

During the course of the program, comparative research was done on 116 military dependents and 165 civilians. Among the civilians, mental retardation was found to be the predominant disability, affecting 69 percent of those participating. Only 24 percent of the civilians displayed the characteristic personality and behavioral disorders which affected 68 percent of the military youngsters. Less than 8 percent of each group exhibited primary disabilities ranging from congenital malformations, accidents, injuries and poisonings, psychotic disorders, severe mental retardation, and hay fever and asthma.

The process of separating the characteristics of the military and civilian cases began with a biographical questionnaire which the parents of all participating youngsters were asked to fill out anonymously. The results indicated that military parents came from more varied geographical backgrounds, were more likely than civilians to have come from broken homes, and were better educated than the civilians. They also were younger and employed a variety of techniques in raising and disciplining their own children.

The civilian parents tended to come from rural areas, had less education, but had closer family relationships.

In further comparing the differences between the two sets of parents, project researchers found that 30 percent more of the civilian mothers worked outside the home. The project social worker found that civilian parents were more cooperative than the military families. The military group directed more hostility toward counselors and social workers than the civilians did. Both military mothers and children displayed more anxiety than the civilians.

Marital discord occurred more frequently among the military families and psychological testing revealed that the military children tended toward insecurity and hostility. These youngsters also were found to be more rigid and more prone to self-devaluation and antisocial aggressiveness, characteristics which were not observed among the civilians.

Most of the military dependents had progressed further in school than the civilians in the program and had higher vocational aims, expressing more interest in military and professional careers. The civilians' ambitions leaned more toward the business world and to service occupations.

A major problem in dealing with the military youngsters was the reluctance of their parents to reveal personal or family problems until they developed a high degree of trust in the counselors or social workers. This reluctance appeared to stem from fears about the effect disclosures of their problems might have on their military careers. Parents needed assurance that their responses would be kept confidential and that individual results would not be sent to any military authority. Cooperation of both parents and children increased when they understood that no report of the rehabilitation service program would be given to military personnel unless parents provided a written release.

From the point of view of the project itself, the good will and approval of the base commanding officer was crucial to an effective program. It was found best to get official clearance for any new rehabilitation service program involving military families, even though the plan involved working with them as off the base.

The project itself was entirely civilian, operating under a demonstration grant from the South Carolina Vocational Rehabilitation Department and supported in part by federal funds from SRS. The program was headquartered on the grounds of the Beaufort Regional Technical Center.

A team of eight full-time and three part-time rehabilitation workers staffed the project. The supervisor, who also acted as a counselor, was responsible for overall coordination and maintaining contacts with other agencies. Counselors worked directly with the youthful clients, often assuming the role of an understanding "big brother" and serving as "interpreter" between teenager and parents when communication problems arose. Two staff evaluators conducted the testing program, administering a total of 31 different written tests to explore the youngsters' rehabilitation potential. The evaluators suggested possible vocational courses for program participants according to the test results.

The staff social worker gathered background information from the youngsters, their parents, school officials, and others in the community and served as a link with the families. A part-time psychologist provided individual therapy and family counseling, and also administered a range of standardized tests to the youngsters.

As research and counseling began to establish that the problems of the military youngsters stemmed from the unique strains of their family life, it became clear that any successful rehabilitation effort would have to involve parents. In fact, it was concluded that if the young dependents were to be helped, their entire families also must be rehabilitated and trained.

In particular, these families must be aided in becoming closer and more unified and in learning how to ward off difficulties arising from their frequent separations and periodic moves around the country and around the world.

Methods of promoting more family group recreational activities must be explored. Special attention should be given to developing better means of absorbing military families into the civilian culture and community surrounding their installations. Parents frequently need as much counseling as their children. Attempts should be made to help them learn how better to manage their youngsters and understand their development.

However, as in any successful rehabilitation program, the individual needs of the clients must remain paramount.

During the course of the Beaufort project, 152 rehabilitation plans were designed for both military and civilian youngsters. A total of 25 young clients had been successfully rehabilitated and were gainfully employed when the project staff reported on its progress.

Facilities from the Air Station, the local public school system, the technical center where the project was located, and Beaufort industries helped to provide a comprehensive program of rehabilitation services.

One of the program's stated goals was to maintain a comprehensive progress record for each client and establish a system for transmitting significant information about young military dependents to rehabilitation authorities near wherever the child's family is next stationed.

If the nationwide network of services to young military dependents envisioned at the start of the project is to be realized, a standardized process of communicating this information must be devised.

The Beaufort project has demonstrated that there are significant differences between troubled military youngsters and their counterparts in the civilian world. The special needs of these military dependents were defined clearly enough for us to conclude that vocational rehabilitation programs must be tailored for them. They are a distinct group with problems unique enough to warrant institution of "two track" vocational rehabilitation programs in the military base communities.

Dr. Chandler is Supervisor of Research and Planning for the State Department of Vocational Rehabilitation, South Carolina.

The Administrative File

Each month the SOCIAL AND REHABILITATION RECORD will carry a listing of SRS administrative issuances for a previous month. Over the course of a year, the RECORD will have presented a complete bibliography of administrative issuances for the year.

The following are the administrative issuances for the month of September 1973. (Abbreviations key: **PR**—Program Regulations; **PRG**—Program Regulations Guides; **PI**—Program Instructions; **IM**—Information Memoranda; **FSI**—Field Staff Information and Instruction Series; **AO**—Administrator's Office; **MSA**—Medical Services Administration; **APA**—Assistance Payment Administration; **CSA**—Community Services Administration; **RSA**—Rehabilitation Services Administration; **NCSS**—National Center for Social Statistics.)

When ordering reports, please specify the appropriate room number for the particular report: For NCSS reports, write NCSS Reports Clerk, Room 2620; for PR reports, write PR Reports Clerk, Room G-115B; for AO reports, write AO Reports Clerk, Room G-115B; and for all other reports, write Reports Clerk, Room 5219.

Send all requests with the appropriate room number to Social and Rehabilitation Service, U.S. Department of Health, Education, and Welfare, 330 C Street, S.W., Washington, D.C. 20201.

APA-PI-74-3: Cuban Refugee Program—Preparation for Conversion of Cuban Refugee Assistance Cases to Program of Supplemental Security Income (SSI) (9/7/73).

APA-PI-74-4/MSA-PI: State Plan Amendment Preprint—Agency manuals; pass-on of OASDI increases; residence; rent payments (9/25/73).

APA-PRG-2(C-1): APA Compilation of Program Regulation Guides—Methods for Determination of Eligibility; *REVOCATION* (9/7/73).

PS&DS-NCSS-PI-7/RSA-PI-74-9: A) Identification on Form RSA-300 of Supplemental Security Income (SSI) Recipients Served under the Recipient Rehabilitation Program (RRP) and B) Quarterly Submittal and Processing of the RSA-300 data (9/26/73).

PR-10-2(-4); 10-3(C-3); 10-11 (C-9); 20-7(C-7): Fair Hearings, Methods of Eligibility Determination, and Incorrect Payments.

AO-IM-74-13: Continued Absence of the Parent from the Home (9/4/73).

AO-IM-74-14: Social Services.

AO-IM-74-15: Reasonable Charges—Medical Assistance Program (9/13/73).

PR 1-6: Administration of Grants—All SRS Programs (9/19/73).

PR 10-6(C-2); 10-7(C-1); 10-10 (C-1); 10-11(C-10); 10-13; 20-7 (C-9); 20-8(C-1); 20-11: Amendments to Implement Several Sections of H.R. 1 (9/20/73).

AO-IM-74-16: Proposed Regs on Sterilization (9/21/73).

AO-IM-74-17: Correction Notice to Social Services (9/21/73).

AO-IM-74-18: Fraud in the Medical Assistance Program (9/27/73).

PR 10-11(C-11): Cost Allocation Plans (9/26/73).

PR 10-11(C-12): Age and School Attendance in AFDC (Townsend v. Swank) (9/27/73).

AO-IM-74-19: SRS Index and Check List (9/30/73).

MSA-IM-74-6: U.S. District Court Decision on Hill Burton Hospitals Exclusion of Medicaid Recipients (Rosezlla Cook *et al* v. Ochsner Foundation Hospital, *et al*) (9/10/73).

MSA-PIM No. 74-3: Filing of State Plan Amendments to Implement Section 255 of P.L. 92-603 (9/5/73).

MSA-FSI-74-16: Summary of Second EPSDT Progress Report for Period Ending June 30, 1973 (9/4/73).

MSA-FSI-74-17: Medicaid Financial Review Objective—Instructions & Suggestions for High Payoff Activity (9/11/73).

MSA-FSI-74-18: Workshop on Section 1903(g) of the SSA (Utilization Review under Section 207 of the 1972 Amendments) (9/6/73).

MSA-FSI-74-19: Final Reports on Utilization Review and Civil Rights Checklists (9/7/73).

MSA-FSI-74-20: Effect of the Supplemental Security Income Program on Health Insurance Buy-IN (9/20/73).

MSA-FSI-74-21: Skilled Nursing Home Status Reports (9/20/73).

MSA-FSI-74-22: EPSDT Progress Report Update (9/20/73).

MSA-FSI-74-23: Sixth Annual Conference of State Medicaid Program Directors and Consultants (9/21/73).

MSA-FSI-74-24: Contract SRS 72-64, Comparison of State Agency and Fiscal Agent Performance under Medicaid—Distribution of Final Report (9/25/73).

RSA-IM-74-12: Transmission of a Report of the National Conference of Vocational Rehabilitation and State Alcoholism Agency Directors on, "Coordinated Rehabilitation Services for People with Alcoholism" (9/5/73).

RSA-IM-74-13: Effective Vocational Guidance of the Deaf (9/6/73).

RSA-IM-74-14: Survey of Career Opportunities for the Deaf (9/6/73).

RSA-IM-74-15: Department of Labor Sheltered Workshop Study (9/17/73).

RSA-IM-74-15: The Rehabilitation Act of 1973—Public Law 93-112 (9/28/73).

RSA-PI-74-8: Vocational Rehabilitation Program Under the Supplemental Security Income (SSI) Provisions of the Social Security Act. Make Ready Cost for the SSI-VR Program (9/10/73).

RSA-PI-74-9: A) Identification on Form RSA-300 of Supplemental Security Income (SSI) Recipients Served under the Recipient Rehabilitation Program (RRP) and B) Quarterly Submittal and Processing of the RSA-300 Data (9/26/73).

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STAFF PHYSICAL THERAPIST for new comprehensive program for mentally retarded. Pediatric experience and knowledge of Spanish preferred. Good fringe benefits. Write: Dr. Susan Gordon, Director of Rehabilitation Services, Bronx State Developmental Services, 1410 Pelham Parkway, Bronx, N.Y. 10461.

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